MEDICAL ASSISTANCE ADMINISTRATION

OXYGEN AND RESPIRATORY THERAPY

Billing Instructions

October 2003

[Chapter 388-552 WAC]

About this publication

This publication supersedes all previous MAA Oxygen & Respiratory Therapy Billing Instructions.

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Important Contacts

Where do I call for information to become a DSHS provider, to submit a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

Where do I call if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Medical Assistance Customer Services Center (MACSC)
(800) 562-6188

Prior authorization and limitation extensions?

MAA Medical Request Coordinator
Division of Medical Management
Fax: (360) 586-1471

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Claims Help Desk
(360) 725-1267

Internet Billing?

http://maa.dshs.wa.gov/ecs.htm

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Definitions

This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance Program.

By Report (BR) - A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. MAA may require the provider to submit a written report to determine reimbursement.

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government. [WAC 388-500-0005]

Compressor - A pump driven appliance which mechanically condenses atmospheric air into a smaller volume under pressure. In respiratory therapy, it is used to forcefully nebulize liquid solutions or emulsions into a vapor state, or mist for inhalation.

Concentrator - A device which increases the concentration of oxygen from the air.

Department - The state Department of Social and Health Services [DSHS].

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated by Medicare for providers which provides transaction information on claims submitted to Medicare for payment/processing.

Managed Care – A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services [see WAC 388-538-050].

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment. [WAC 388-552-005]

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification card(s) – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- **Part A** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- **Part B** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Oxygen - USP medical grade liquid oxygen or compressed gas. [WAC 388-552-005]

Oxygen System - All equipment necessary to provide oxygen to a person. [WAC 388-552-005]

Patient Identification Code (PIC) - An alphanumeric code which is assigned to each Medicaid client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tie breaker).

Portable Oxygen System - A small system that allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence. [WAC 388-552-005]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients.

Remittance and status report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Respiratory Care Practitioner – A person certified by the Department of Health and employed in the treatment, management, diagnostic testing, rehabilitation, and care of patients with deficiencies and abnormalities which affect the cardiopulmonary system and associated aspects of other systems, and are under the direct order and qualified medical direction of a physician. (Refer to chapter 18.89 RCW and chapter 246-928 RCW)

Revised Code of Washington (RCW) - Washington State laws.

Stationary Oxygen System – Equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use. [WAC 388-552-005]

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Usual & Customary Fee - The fee that the provider typically charges the general public for the product or service.

Ventilator - A device to provide breathing assistance to clients with neuromuscular diseases, thoracic restrictive diseases, or chronic respiratory failure consequent to chronic obstructive pulmonary disease. It includes both positive and negative pressure devices.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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Oxygen and Respiratory Therapy

What is the purpose of the Oxygen & Respiratory Therapy Program? [Refer to WAC 388-552-001 (1)(a)]

The purpose of this program is to provide medically necessary oxygen and/or respiratory therapy equipment, services, and supplies to eligible Medical Assistance Administration (MAA) clients who:

- Reside at home; or
- Reside in a nursing facility; and
- Who are not enrolled in a managed care plan.

Who should use these billing instructions?
[Refer to WAC 388-552-001 (1)(b) and (2)]

Providers who furnish oxygen and respiratory therapy equipment, supplies, and services to eligible, MAA fee-for-service clients should use these billing instructions. Instructions for clients with Medicare as their primary insurer are covered in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

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Client Eligibility

Who is eligible? [Refer to WAC 388-552-100 (1)]

MAA fee-for-service clients are eligible for oxygen and respiratory therapy equipment, supplies, and services.

Clients with one of the following identifiers on their Medical Identification (ID) card are subject to the following limitations:

Exception

CNP-QMB or MNP-QMB (Categorically Needy Program/Qualified Medicare Beneficiaries and Medically Needy Program/Qualified Medicare Beneficiaries) **–** The clients are covered by Medicare and Medicaid as follows:

- If Medicare covers the service, MAA will pay the lesser of:
  - ✓ The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or
  - ✓ MAA's maximum allowable for that service minus the amount paid by Medicare; or
- If Medicare denies or does not cover equipment, supplies, or services that MAA covers according to these billing instructions, MAA reimburses at MAA's maximum allowable; however, MAA does not reimburse for clients on the Qualified Medicare Beneficiaries (QMB) Only Program.

Can clients enrolled in an MAA managed care plan receive oxygen and respiratory therapy services?

[Refer to WAC 388-552-100 (2)]

Oxygen and respiratory therapy equipment and supplies are covered services under the client's managed care plan when the services are medically necessary. Clients whose Medical ID cards have an HMO identifier in the HMO column are enrolled in a managed health care plan.

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Provider Requirements

What is my responsibility as an oxygen provider?

[Refer to WAC 388-552-200]

As an oxygen provider, it is your responsibility to:

- Work within your designated scope of practice as outlined in current WAC and RCW.
- Check the client's Medical Identification card to verify that the client is eligible before providing the service. If the client's Medical ID card has an indicator in the HMO column, contact their managed care plan for all coverage conditions and limits on services.
- Verify that the client's original prescription is signed and dated by an authorized prescriber no more than 90 days prior to the initial date of service. The documentation must include, at a minimum:
  - ✓ The client's medical diagnosis, prognosis, and documentation of the medical necessity for oxygen and/or respiratory therapy, equipment, supplies, and/or services, and any modifications.
  - ✓ If oxygen is prescribed:
    - ➢ Flow rate of oxygen (e.g., 2 liters per minute).
    - ➢ Frequency and duration of oxygen use (e.g., 10 minutes per hour).
    - ➢ Lab values or oxygen saturation measurements upon client's discharge from the hospital: arterial blood gases without oxygen and/or oxygen saturation levels.
    - ➢ Estimated duration of need.
- Make regular deliveries of medically necessary oxygen to the client's nursing facility or private residence.
- Provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.
- Maintain all rental equipment in good working condition on a continuous (24-hour, seven-days-a-week) basis.
- Provide a minimum warranty period of one year for all client-owned medical equipment (excluding disposable/non-reusable supplies).

- **Keep a copy of all warranties in your files and provide them to MAA upon request.** If the warranty expires, information must include the date of purchase and the warranty period.

- Bill MAA your usual and customary fee for clients not in managed care and residing at home or in a nursing facility.

What do I need to do to renew an oxygen prescription?

[WAC 388-552-220]

Oxygen providers must:

- Obtain a renewed prescription every six months if the client's condition warrants continued service; and

- Verify, at least every six months, that oxygen saturations or lab values substantiate the need for continued oxygen use for each client. The provider may perform the oxygen saturation measurements**. MAA does not accept lifetime certificates of medical need (CMNs).**

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How MAA's Requirements Differ from Medicare's

MAA's policies on respiratory equipment, services, and supplies are consistent with Medicare's **with the following exceptions**:

Oxygen and Oxygen Equipment

- MAA covers chronic and continuous use of medically necessary oxygen and respiratory therapy equipment and supplies for eligible clients who reside in nursing facilities.

- MAA does not recognize lifetime CMNs for clients who are Medicare/Medicaid eligible and for whom Medicare has denied or stopped oxygen benefits.

- MAA requires logs of oxygen saturations or lab values to substantiate medical necessity for continuous oxygen use at least every six months for all clients.

- MAA covers oxygen for clients 18 years of age or older with $SaO_2 \leq 88\%$ or $PaO_2 \leq 55mm$ on room air and when prescribed by a physician.

- MAA covers oxygen for clients 17 years of age or younger to maintain the level of SaO_2 at:

  - ✓ 92%, or
  - ✓ 94% in a child with cor pulmonale or pulmonary hypertension.

- MAA covers respiratory care practitioners and ventilation therapist services in the client's home. Therapist services are included in the nursing facility per diem for eligible clients residing in nursing facilities.

- MAA allows the provider of the respiratory services to measure oximetry readings for every six-month's renewal.

- MAA pays for six-month maintenance/service checks only on client-owned ventilators and CPAPs.

- MAA does not pay for six-month maintenance/service checks unless the service is actually provided.

Continuous Positive Airway Pressure (CPAP) System

[Refer to WAC 388-552-320]

- MAA allows the rental of a CPAP system for an initial two-month period.
- MAA requires the provider to convert CPAP rentals to a purchase when, at the end of the initial two-month rental period, the attending physician determines that:
  - ✓ The client's apnea is chronic; and
  - ✓ The CPAP is the least costly, most effective treatment modality.

Suction Pumps/Supplies [WAC 388-552-360]

- MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.
- MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:
  - ✓ [The] travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or
  - ✓ The client requires suctioning while away from the client's place of residence.

Tracheostomy Care Supplies

- MAA covers tracheostomy holders, neckbands, and ties.
- See the *Fee Schedule* for limitations of items in this section.
- MAA reimburses for gloves, sterile water, suction instruments, etc., when billed by Durable Medical Equipment (DME) providers and pharmacists. To become a DME or pharmacy provider, see the *Important Contacts* section.

Coverage

Stationary Oxygen Systems

What is covered?

- MAA covers **one** payment for stationary oxygen systems, **per month**. MAA considers all of the following as stationary oxygen systems:

  - ✓ Stationary;
  - ✓ Compressed gaseous;
  - ✓ Stationary liquid; or
  - ✓ A concentrator.

- Regardless of how many stationary oxygen systems are required to ensure the client's oxygen needs are met, MAA considers this one monthly fee as payment in full.

Portable Oxygen Systems

What is covered?

- MAA covers **one** payment for portable oxygen systems, **per month**. MAA considers both portable gaseous and portable liquid as portable oxygen systems.

- Regardless of how many portable oxygen systems are required to ensure the client's oxygen needs are met, MAA considers this one monthly fee as payment in full.

Stationary Oxygen Contents

What is covered?

MAA covers a maximum of **one** payment for stationary oxygen contents, **per month**, when both the stationary and portable oxygen systems are owned by the client.

Portable Oxygen Contents

What is covered?

MAA covers a maximum of **one** payment for portable oxygen contents, **per month**, when one of the following is true:

- The client owns a concentrator and owns or rents the portable system; or
- The client uses only a portable oxygen system.

Continuous Positive Airway Pressure (CPAP) and Supplies

What is covered? [WAC 388-552-320 (1)(2)]

- MAA covers the **rental** and/or purchase of medically necessary CPAP equipment and related accessories when **all** of the following apply:
  - ✓ The results of a prior sleep study [polysomnogram] indicate the client has sleep apnea;
  - ✓ The client's attending physician determines that the client's sleep apnea is chronic;
  - ✓ CPAP is the least costly, most effective treatment modality;
  - ✓ The item is FDA-approved; and
  - ✓ The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).
- MAA covers six-month maintenance checks on client-owned CPAPs.

> ☞ **NOTE:** Use type of service "R" and modifier "MS" to bill MAA. **The service is billable when actually performed.**

- MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA will purchase it.

CPAP Accessories and Services that are NOT covered:

MAA does NOT cover accessories/services not specifically identified in the fee schedule in this document.

Ventilator Therapy, Equipment, and Supplies

What is covered? [Refer to WAC 388-552-330 and WAC 388-552-350]

- MAA covers medically necessary ventilator equipment rental and related disposable supplies when **all** of the following apply:

  ✓ There is a prescription for the ventilator;

  ✓ The ventilator is to be used exclusively by the client for whom it is requested;

  ✓ The ventilator is FDA-approved; and

  ✓ The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG). Prescribed medically necessary accessories (such as humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing) are included in the monthly rental payments.

- MAA covers a secondary (back-up) ventilator at 50% of the monthly rental, if medically necessary.

  ☞ **NOTE:** You **must** use modifier "**U2**" when submitting a claim for a second ventilator, for the same client, for the same rental period.

- MAA covers the purchase of the following durable accessories for client-owned ventilator systems:

  ✓ Battery charger, replacement;
  ✓ Heavy-duty battery replacement;
  ✓ Battery cables, replacement;
  ✓ Nasal cannula or mask;
  ✓ Tubing;
  ✓ Breathing circuits; and
  ✓ Variable concentration masks.

- MAA covers and requires that one maintenance/service visit every six months for client-owned equipment must be done on client-owned ventilators.

  ☞ **NOTE:** Use type of service "R" and modifier "MS" to bill MAA.

- MAA covers ventilator therapy services when they are prescribed, medically necessary, and provided by a certified respiratory care practitioner.

What is not covered? [Refer to WAC 388-552-350 (3)]

MAA does not reimburse separately for ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

Infant Apnea Monitor Program

Who may provide Infant Apnea Monitors? [Refer to WAC 388-552-230 (1)]

Oxygen providers that have a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care directing their apnea monitor program may provide these monitors.

Additional Responsibilities of Infant Apnea Monitor Providers
[Refer to WAC 388-552-230 (2)(3)]

Infant Apnea Monitor providers must:

- Have a neonatologist's confirming assessment and recommendation as a second opinion in the client's file unless the client's diagnosis is:

  - ✓ Apnea of prematurity;
  - ✓ Primary apnea (e.g., ventilator-dependent infant);
  - ✓ Obstructed airway; or
  - ✓ Congenital conditions associated with apnea (e.g., cardioarrhythmia); and

- Keep all of the following in the client's file:

  - ✓ The prescribing physician's prescription;
  - ✓ Documentation supporting the medical necessity for apnea monitoring;
  - ✓ The estimated length of time an apnea monitor will be needed; and
  - ✓ Regardless of diagnosis, a neonatologist's written clinical evaluation justifying each subsequent rental period.

☞ **NOTE:** Enter the prescribing physician's provider number in field 17a on the HCFA-1500 claim form when billing MAA.

What is covered? [WAC 388-552-340]

- MAA covers infant apnea monitors on a rental basis.

- The initial rental period must not exceed six months.

- MAA includes all home visits for equipment setup, follow-up calls, and training in the rental allowance.

Respiratory Therapy

Scope of Practice [Refer to RCW 18.89.040]

- The scope of practice of respiratory care includes, but is not limited to:

  - ✓ The use and administration of medical gases, exclusive of general anesthesia;
  - ✓ The use of air and oxygen administering apparatus;
  - ✓ The use of humidification and aerosols;
  - ✓ The administration of prescribed pharmacologic agents related to respiratory care;
  - ✓ The use of mechanical or physiological ventilatory support;
  - ✓ Postural drainage, chest percussion, and vibration;
  - ✓ Bronchopulmonary hygiene;
  - ✓ Cardiopulmonary resuscitation as it pertains to establishing airways and external cardiac compression;
  - ✓ The maintenance of natural and artificial airways and insertion, without cutting tissues, of artificial airways, as ordered by the attending physician;
  - ✓ Diagnostic and monitoring techniques such as the measurement of cardiorespiratory volumes, pressures, and flows; and
  - ✓ The drawing and analyzing of arterial, capillary, and mixed venous blood specimens as ordered by the attending physician or an advanced registered nurse practitioner as authorized by the board of nursing under RCW 18.88. [1987 c 415 S 5.]

- In addition, MAA expects respiratory therapists to include the following in their visits:

  - ✓ Evaluation of equipment settings for appropriateness in meeting the client's present needs and safety in the client's immediate home environment;
  - ✓ Checks of equipment and assurance that the equipment settings continue to meet the client's needs; and
  - ✓ Communications of concerns or recommendations to the client's physician.

What is covered? [Refer to WAC 388-552-350 (1)(2)]

- MAA covers prescribed medically necessary respiratory therapy services in the home.

- The following professional respiratory therapy services must be provided by a certified respiratory care practitioner:

  - ✓ Initial home visit-patient intake and evaluation;
  - ✓ Subsequent home visits, including oximetry services; and
  - ✓ Professional visit for the administration of aerosolized medications.

What is not covered? [Refer to WAC 388-552-350 (3)]

MAA does not reimburse separately for respiratory therapy services provided to clients residing in nursing facilities. These services are included in the nursing facility per diem rate.

Repairs

What is covered?

MAA covers the repair of client-owned non-disposable equipment after the expiration of the warranty period.

What is not covered? [Refer to WAC 388-552-410(2)(c)]

MAA does not cover repairs (including materials and labor) of:

- Equipment or parts under warranty. This includes equipment that was rented and subsequently considered client-owned by MAA;
- Rented equipment; or
- Equipment, when there is evidence of malicious damage, culpable neglect, or wrongful disposition. MAA will not replace such equipment.

How do I get reimbursed for repairs?

Bill MAA using the repair code along with the appropriate units. Keep the following on file and accessible to MAA upon request:

- Actual repair costs;
- Statement of warranty coverage; and
- Date of purchase.

MAA does not reimburse separately for:

- **Telephone calls;**
- **Mileage; or**
- **Travel time.**

These services are included in the reimbursement for other equipment and/or services. [Refer to WAC 388-552-400 (2)]

Miscellaneous Oxygen-Related Durable Medical Equipment (DME)

Does MAA cover oxygen-related DME not specifically addressed in the Fee Schedule?

MAA does cover some oxygen-related DME after medical review. When submitting your claim for miscellaneous oxygen-related DME, you must also fax supporting documentation to:

MAA
Respiratory Program
(360) 586-5299

For your convenience, we have attached a sample fax form at the end of this document. Include the following supporting documentation with your fax:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of piece of equipment;
- Invoice;
- Prescription; and
- Explanation of client-specific, medical necessity.

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Prior Authorization

What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LEs) are forms of prior authorization.**

Expedited Prior Authorization (EPA)

Expedited prior authorization does not apply to out-of-state care. Out-of-state care is not covered. Out-of-state hospital admissions are not covered unless they are emergency admissions.

What is the EPA process?

MAA's EPA process is designed to eliminate the need for written/fax authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling provider to create an "EPA" number when appropriate.

How is an EPA number created?

The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the criteria set that indicates what procedure you are billing for and what information qualifies for use of the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: When billing E0570 for a **Nebulizer** when the client is 2 years old and has been diagnosed with acute bronchiolitis, the expedited prior authorization number would be **870000900.** (**870000** = first six digits of all expedited prior authorization numbers, **xxx** = last three digits of an EPA number, indicating the equipment your are billing for and the clinical criteria met.

Note: When the client's situation does not meet published criteria, written/fax prior authorization is necessary.

Expedited Prior Authorization Guidelines

A. Diagnoses

Only information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation. What documentation is required when using expedited prior authorization?

The billing provider must have documentation of how expedited criteria were met, and have this information in the client's file available to MAA on request.

Which services require EPA?

EPA is required for services noted in MAA's billing instructions as needed after the description of the procedure code.

Limitation Extensions

What is a Limitation Extension?

A limitation extension (LE) is MAA's authorization for the provider to furnish more units of service than are allowed in Washington Administrative Code (WAC) and MAA's billing instructions. The provider must provide justification that the additional units of service are medically necessary.

Limitation Extensions do not override the client's eligibility or program limitations. Not all categories of eligibility can receive all services. **For Example:** Kidney dialysis is not covered under the Family Planning Only Program.

How do I get LE authorization?

Obtain an LE by using the written/fax authorization process on next page.

Written/Fax Authorization

What is written/fax authorization?

Written or fax authorization is the paper authorization process providers must use when requesting an LE.

How do I obtain written/fax authorization?

Send or fax your request to the MAA Medical Request Coordinator (see Important Contacts).

Note: For your convenience, a sample form containing the required information is on the next page. You are not required to use this particular form.

How do I obtain the DSHS Oxygen and Respiratory Limitation Extension form 15-298?

To **download** DSHS forms, visit:
http://www1.dshs.wa.gov/msa/forms/eforms.html

To **have a paper copy sent** to you:
Phone DSHS Forms and Records Management Service: (360) 664-6047
Fax DSHS Forms and Records Management Service: (360) 664-6186

Be sure to include in your request:

- The form number and name
  DSHS 15-298 Oxygen and Respiratory Limitation Extension form;
- The quantity you want;
- Your name;
- Your office/organization name;
- Your complete mailing address.

Reimbursement

For clients on Medicare and Medicaid, MAA reimburses providers the coinsurance and deductible. See Durable Medical Equipment Regional Carrier (DMERC) Region D Supplier's Manual for Medicare policies.

Rentals [Refer to WAC 388-552-410 (1)]

- Submit claims for rentals only once a month.
- Rental rates are on a per-month basis, unless otherwise specified.
- Types of rental equipment:

  - ✓ Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and
  - ✓ Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client.

- The monthly rental rate includes, but is not limited to:

  - ✓ A full service warranty covering the rental period;
  - ✓ Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;
  - ✓ All medically necessary accessories and disposable supplies, unless separately billable according to these billing instructions;
  - ✓ Instructions to the client and/or caregiver for safe and proper use of the equipment; and
  - ✓ Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

In the event of a client's ineligibility, death, or discontinued use of equipment, rental fees must terminate on the last day of eligibility, life, or medically necessary usage. Reimbursement will be prorated in these cases.

Purchases [Refer to WAC 388-552-410 (2)]

- Purchased equipment becomes the property of the client.
- MAA reimburses for:

  - ✓ Equipment that is new at the time of purchase. This may be the same equipment that is provided during the initial two-month rental; and
  - ✓ One maintenance visit every six months for client-owned ventilators and CPAPs.

- MAA does not reimburse for:

  - ✓ Defective equipment; or
  - ✓ The cost of materials (and associated labor) covered under the manufacturer's warranty.

- The reimbursement rate for client-owned equipment includes, <u>but is not limited to</u>:

  - ✓ A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/non-reusable supplies;
  - ✓ Instructions to the client and/or caregiver for safe and proper usage of the equipment; and
  - ✓ The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

- **The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.**

Owned Respiratory Therapy Equipment

[Refer to WAC 388-552-410 (2)]

- MAA reimburses for only one maintenance and service visit every six months for client-owned ventilators and CPAPs.

> ☞ **NOTE:** You must use type of service "R" and modifier "MS" when submitting claims for a six-month maintenance check. A six-month maintenance check will be denied unless BOTH type of service "R" and modifier "MS" are used.

- The reimbursement for the six-month maintenance check includes, but is not limited to, all of the following:

  - ✓ Maintaining all equipment in good working condition;
  - ✓ Making any adjustments according to manufacturer's specifications; and
  - ✓ Making any routine cleaning, servicing, and/or repairs as recommended by the manufacturer.

Oxygen System Components

- The monthly reimbursement for stationary oxygen systems includes all of the following:

  - ✓ Oxygen contents;
  - ✓ Tubing;
  - ✓ Regulator;
  - ✓ Flowmeter;
  - ✓ Humidifiers
  - ✓ Administration device (e.g., tracheostomy tube connector);
  - ✓ Hood and/or tent;
  - ✓ Cannula mask; and
  - ✓ Related supplies.

- The monthly reimbursement for portable oxygen systems includes all of the following:

  - ✓ Tubing;
  - ✓ Regulator;
  - ✓ Flowmeter;
  - ✓ Humidifiers;
  - ✓ Administration device (e.g., tracheostomy tube connector);
  - ✓ Hood and/or tent;
  - ✓ Cannula mask; and
  - ✓ Related supplies.

Billing Dates

Providers must bill with **all** dates of service in which the equipment/supplies were used.

☞ **EXAMPLE:** When billing an oxygen system monthly fee for January 2003, dates should be 010103 to 013103.

Nursing Facilities [Refer to WAC 388-552-390]

- MAA reimburses for the chronic and continuous use of medically necessary oxygen and oxygen and respiratory equipment and supplies by eligible clients who reside in nursing facilities.

- Do not bill MAA or the client for the following services which are included in the nursing facility's per diem rate:

  ✓ Oxygen and oxygen equipment and supplies used in emergency situations; and

  ✓ Respiratory and ventilator therapy services.

- Nursing facilities with a "piped" oxygen system may submit a written request to MAA for permission to bill MAA for oxygen.

  Send your requests to:

  Professional Reimbursement Section
  Division of Budget and Finance
  Department of Social and Health Services
  PO Box 45510
  Olympia, WA 98504-5510

- Reimbursement for supplies is included in the rental reimbursement for oxygen systems or ventilators, unless otherwise indicated.

Inhalation Drugs & Solutions [Refer to WAC 388-552-370]

Inhalation drugs and solutions are included in the Prescription Drug Program. These must be billed only by pharmacists using National Drug Codes (NDCs). To obtain a copy of MAA's Prescription Drug Program Billing Instructions, write to:

Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
or call
1-800-562-6188

Oximeters **[Refer to WAC 388-552-380]**

- MAA covers oximeters for clients when they are 17 years of age or younger, in the home, and have one of the following conditions:

  - ✓ **The child has chronic lung disease and is on supplemental oxygen**.
    This child is at risk for desaturation with sleep, stress, or feeding and has a narrow margin for progression to respiratory failure. Weaning off oxygen can more efficiently be done with home oximetry.

  - ✓ **The child has a compromised or artificial airway**.
    This is the child with congenital anomalies, neurodevelopmental compromise, and artificial airways such as nasal stents and tracheostomies. This child is at risk for major obstructive events or aspiration events.

  - ✓ **The child has chronic lung disease requiring ventilator or BiPAP support**.
    Home oximetry is an essential monitoring device for such compromised children as well as for weaning off support, if possible. Children who use BiPAP support are at risk for atelectasis or pneumonia along with their risk for hypoventilation. Early detection of desaturation can provide time to intervene with other measures to avoid severe compromise.

- The provider must review oximetry needs and fluctuations in oxygen levels monthly and log results in the client's records.

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Fee Schedule

Notes About the Fee Schedule

Procedure Code Description: The description of each procedure code will tell you if:

- A modifier is required.
- A limit applies.
- An item/service is bundled/unbundled.
- Prior authorization is required.

Note: New HCPCS codes are designated with a "new" icon next to the code. Those HCPCS codes with a "#" symbol in the maximum allowable Rental or Purchase columns are not covered by MAA.

Maximum Allowance: The *RENTAL* and *PURCHASE* columns indicate the maximum dollar amount or percentage of billed amount payable by MAA. Rentals are calculated on a monthly basis unless otherwise indicated. In those instances where rental is required prior to purchase, the rental price is applied towards the purchase price.

Rentals: From and to dates are required on all rental billings.

Modifiers: **You must use the appropriate modifier with the procedure code when indicated:**

Equipment Rental -	Use modifier "RR"
Equipment Purchase -	Use modifier "NU" (eff. 10/03)
Six Month Maintenance Fee -	Use modifier "MS" (for Ventilators and CPAPs only)
Second Ventilator (Backup) -	Use modifier **"**U2" (eff. 7/1/03)
Backup Equipment	Use modifier "TW" in addition to any other required modifier when billing for back-up equipment, other than ventilators (eff. 7/1/05). For backup ventilators, continue to use modifier "U2".

Do Not Bill With: **Any procedure code listed in the "Do Not Bill With" column of the fee schedule is <u>AT NO TIME</u> allowed in combination with the primary code located in the "Procedure Code" column.**

Bill MAA your usual and customary fee (the fee you bill the general public). MAA's payment will be either your usual and customary fee or MAA's maximum allowable rate--whichever is lower.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Apnea Monitor and Supplies

Apnea monitor, without recording feature.	**E0618**		**#**	**#**
Apnea monitor, with recording feature. **Maximum of six months rental allowed per lifetime. Modifier RR required.**	**E0619**		**280.35**	
Electrodes (e.g., Apnea monitor), per pair. **Purchase only. Modifier NU required.** **For use only when client is unable to tolerate carbon patch electrodes.** **Limit: 15 every 30 days.**	**A4556**	**A4558**		**10.32**
Lead Wires, e.g. apnea monitor per pair	**A4557**		**#**	**#**
Conductive paste or gel. **Purchase only.** **Modifier NU required.**	**A4558**	**A4556**		**5.45**
Apnea belt kit (includes 2 belts, 4 electrodes, and 4 lead wires). Purchase only. **Modifier NU required.** **Limit: 2 every 30 days.**	**E1399 w/EPA #870000904**	**A4556 A4557**		**25.92**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Continuous Positive Airway Pressure System (CPAP)

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase
Continuous airway pressure (CPAP) device.* • **Requires results of sleep study performed in an MAA-approved sleep center.** • **Rental Limit: 1 unit per month, maximum of 2 months rental.** • **Purchase required after 2 months mandatory rental. Client compliance and effectiveness must be documented prior to purchase.** • **Purchase limit: 1 unit per client, every 5 years. Purchase price is amount allowed after 2 months mandatory rental.** • **Modifier RR or NU required.**	**E0601**	**E0470 E0471 E0472**	**$111.71**	**$893.68**
Full face mask, used with positive airway pressure device, each. **Limit: 1 every 6 months.**	**A7030**	**7031**		**188.64**
Face mask interface, replacement for full face mask, each. **Limit: 1 every 3 months.**	**A7031**	**7030**		**69.77**
Replacement cushion for nasal application device, each. **Limit: 1 every 6 months.**	**A7032**	**A7034**		**40.53**
Replacement pillows for nasal application device, pair. **Limit: 1 every 6 months.**	**A7033**	**A7034**		**28.41**
Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap. **Limit: 1 every 6 months.**	**A7034**	**A7032 A7033**		**117.64**
Headgear used with positive airway pressure device. **Limit: 1 every 6 months**	**A7035**			**39.75**
Chinstrap used with positive airway pressure device. **Limit: 1 every 6 months**	**A7036**			**18.20**
Tubing used with positive airway pressure device. **Limit: 1 every 6 months**	**A7037**	**A7010**		**41.02**
Filter, disposable, used with positive airway pressure device. **Limit: 2 every 30 days.**	**A7038**			**5.39**

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Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Continuous Positive Airway Pressure System (CPAP) (cont.)

Filter, nondisposable, used with positive airway pressure device. **Limit: 1 every 6 months.**	**A7039**			**$15.33**
Oral interface, used with positive airway pressure device, each.	**A7044**		**#**	**#**
Exhalation port (with or without swivel) used with accessories for positive airway devices, replacement only.	**A7045**		**#**	**#**
Water chamber for humidifier, used with positive airway pressure device, replacement, each. **Limit: 1 every 6 months.**	**A7046**			**19.51**
Humidifier, nonheated, used with positive airway pressure device.	**E0561**		**#**	**#**
Humidifier, heated, used with positive airway pressure device. **Purchase only.** **Limit: 1 per 3 years.** **Modifier NU required**	**E0562**			**301.22**
Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (ie:BiPAP S).* • **Requires results of sleep study performed in an MAA-approved sleep center when prescribed for sleep apnea.** • **Purchase required after maximum of 2 months mandatory rental. Client compliance and effectiveness must be documented prior to purchase.** • **Limit: 1 purchase per lifetime per client.** • **Modifier RR or NU required.** • **Purchase price is amount allowed after 2 months mandatory rental.**	**E0470**	**E0601, E0471, E0472**	**256.60**	**2,052.80**

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Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

IPPB Machines and Accessories

IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source. (Includes mouthpiece and tubing.) **Rental only.** **Modifier RR required.**	**E0500**	**E0570**	**93.30**	

Nebulizers and Accessories

*MAA now allows providers to bill for the rental of nebulizers when there is an expectation that the client will only need a nebulizer for short-term use. If, after 2 months of rental, the client still requires the use of a nebulizer, then the rental must be converted to purchase.

Compressor, air power source for equipment which is not self-contained or cylinder driven. **Rental only.** **Only the following accessories may be billed with this code: A4619, A7525, E1399 w/EPA #870000903, A7006, A7007, A7010-A7012, A7014, and A7015.** **Modifier RR required.**	**E0565**		**51.86**	

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Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase
***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*				
Nebulizer with compressor. • **Only the following accessories may be billed with this code: A7525 or A7015, A7003-A7006, A7013.** • **When AC/DC adapter is available for use with equipment provided, the adapter is considered included in nebulizer reimbursement.** • **Reimbursement includes delivery and instruction on the proper use and cleaning of the equipment.** **Rental allowed for clients with expected short-term use, e.g., acute vs. chronic condition. Purchase required after 2 months of rental. Diagnosis of acute bronchiolitis 466.11, OR 466.19, or acute bronchiolitis 466.0.** • **Purchase price is amount allowed after 2 months mandatory rental.** • **Limit: 1 per client, per 5 years.** • **Modifier RR or NU required.** • **See Expedited Prior Authorization (EPA) Section for clients not meeting Medicare diagnosis criteria.**	**E0570**	**E0500**	**16.10**	**128.80**
Aerosol compressor, battery powered, for use with small volume nebulizer.	**E0571**		#	#
Aerosol compressor, adjustable pressure, light duty for intermittent use.	**E0572**		#	#
Ultrasonic/electronic aerosol generator with small volume nebulizer.	**E0574**		#	#
Nebulizer, ultrasonic, large volume.	**E0575**		#	#
Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter.	**E0580**		#	#
Nebulizer, with compressor and heater.	**E0585**		#	#

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Nebulizers and Accessories (cont.)

Administration set, with small volume non-filtered pneumatic nebulizer, disposable. **May only be used as a backup to A7005** **Purchase only.** **Limit: 1 per client, every 30 days.** **Modifier NU and TW required.**	**A7003**	**A7004**		**2.74**
Small volume nonfiltered pneumatic nebulizer, disposable. **Purchase only.** **Limit: 3 per client, every 30 days.** **Modifier NU required.**	**A7004**	**A7003** **A7005**		**1.80**
Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable. **Purchase only.** **Limit: 1 per client, every 6 months.** **Modifier NU required.**	**A7005**	**A7004**		**30.83**
Administration set, with small volume filtered pneumatic nebulizer. **Purchase only.** **Limit: 1 per client, every 30 days.** **Modifier NU required.** **For Pentamidine administration only.**	**A7006**			**9.54**
Large volume nebulizer, disposable, unfilled, used with aerosol compressor. **Limit: 10 per client, every 30 days.**	**A7007**			**4.61**
Large volume nebulizer, disposable, prefilled, used with aerosol compressor. **Should use combination of A7007 and E1399 with EPA number 870000928.**	**A7008**		**#**	**#**
Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer.	**A7009**		**#**	**#**
Corrugated tubing, disposable, used with large volume nebulizer, 100 feet. **Purchase only.** **Modifier NU required.** **Limit: 1 per client, every 30 days.**	**A7010**	**A7037**		**23.59**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Nebulizers and Accessories (cont.)

Corrugated tubing, nondisposable, used with large volume nebulizer, 10 feet. **Purchase only. Modifier NU required. Limit: 1 per client, every 12 months.**	**A7011**			**1.51**
Water collection device, used with large volume nebulizer. (e.g., aerosol drainage bag) **Only paid in conjunction with E0565. Purchase only. Modifier NU required. Limit: 8 per client, every 30 days.**	**A7012**			**3.78**
Filter, disposable, used with aerosol compressor. **Only when using E0570. Purchase only. Modifier NU required. Limit: 2 per client, every 30 days.**	**A7013**	**A7014**		**0.83**
Filter, non-disposable, used with aerosol compressor or ultrasonic generator. **Only when using E0565. Purchase only. Modifier NU required. Limit: 1 per client, every 3 months.**	**A7014**	**A7013**		**4.49**
Aerosol mask, used with DME nebulizer. **Purchase only. Modifier NU required. Limit: 3 per client, every 30 days.**	**A7015**			**1.88**
Face tent. **Purchase only. Limit: 3 per client, every 30 days. Modifier NU required.**	**A4619**	**E1390**		**1.21**
Dome and mouth piece, used with small volume ultrasonic nebulizer.	**A7016**		**#**	**#**
Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen.	**A7017**		**#**	**#**
Water, distilled, used with large volume nebulizer, 1000ml	**A7018**	**E1399 w/EPA #870000928**		**.38**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Nebulizers and Accessories (cont.)

Sterile water or sterile saline, 1000 ml, used with large volume nebulizer. Limit: 50 per client, every 30 days.	**E1399 w/EPA #870000928**	**A7018**		**2.74**
"Fish" 3-5cc saline vials. **Limit: 200 per client, every 30 days.**	**E1399 w/EPA #870000901**			**.23**

Oxygen and Oxygen Equipment

Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing. **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.**	**E0424**	**A4615-A4620, E0439, E0441-E0444, E0550, E1390, K0671**	**194.48**	
Stationary compressed gas system, purchase: includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.	**E0425**		#	#
Portable gaseous oxygen system, purchase; include regulator, flow meter, humidifier, cannula or mask, and tubing.	**E0430**		#	#
Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing. **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.**	**E0431**	**A4615-A4620, E0434, E0441-E0444, E0550, K0671**	**32.07**	

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase
***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*				
Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents, gauge, cannula or mask and tubing. **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.**	**E0434**	**A4615-A4620, E0431, E0441-E0444, E0550, K0671**	**32.07**	
Portable liquid oxygen system, purchase: includes portable container, supply reservoir, humidifier, flowmeter, contents gauge, cannula or mask, tubing, and refill adapter.	**E0435**		**#**	**#**
Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing. **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.**	**E0439**	**A4615-A4620, E0424, E0441-E0443, E0550, E1390 K0671**	**194.48**	
Stationary liquid oxygen system, purchase; includes use of reservoir, contains indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.	**E0440**		**#**	**#**
Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned). One month's supply equals one unit. **This is a monthly fee.** **Limit: 1 per client, every 30 days.**	**E0441**	**E0424, E0431, E0434, E0439, E0442, E0443, E0444, E0550, E1390 K0671**		**154.27**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Oxygen and Oxygen Equipment (cont.)

Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned). One month's supply equals one unit. **This is a monthly fee.** **Limit: 1 per client, every 30 days.**	**E0442**	**E0424, E0431, E0434, E0439, E0441, E0443, E0444, E1390 K0671**		**154.27**
Portable oxygen contents, gaseous (for use only with portable gaseous system when no stationary gas or liquid system is used). One month's supply equals one unit. **This is a monthly fee.** **Limit: 1 per client, every 30 days.**	**E0443**	**E0424, E0431, E0434, E0439, E0441, E0442, E0444 E1390 K0671**		**21.41**
Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used). One month's supply equals one unit. **This is a monthly fee.** **Limit: 1 per client, every 30 days.**	**E0444**	**E0424, E0431, E0434, E0439, E0441-E0443**		**21.41**
Regulator	**E1453**		**#**	**#**
Stand/rack	**E1355**		**#**	**#**
Immersion external heater for nebulizer	**E1372**		**#**	**#**
Oxygen tent, excluding croup or pediatric tents.	**E0455**		**#**	**#**
Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate. **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.** **(**Rental includes: humidifier, if needed, cannula or mask and tubing.)	**E1390**	**A4620, E0424, E0439, E0441, E0442, E0443, E0444, E0550**	**194.48**	

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Oxygen and Oxygen Equipment (cont.)

Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each	**E1391**		#	#
Portable oxygen concentrator. **Must be billed with E1390** **Monthly rental only.** **Limit: 1 per client, every 30 days.** **Modifier RR required.**	**K0671** 	**A4615-A4620, E0424, E0431, E0434, E0439, E0441-E0443, E0444, E0550**	**32.07**	
Oxygen and water vapor enriching system with heated delivery.	**E1405**	**E1406**	#	#
Oxygen and water vapor enriching system without heated delivery.	**E1406**	**E1405**	#	#

Professional Services

Respiratory therapy home visit: subsequent, includes oximetry services.	**94760 w/EPA #870000916**	**94656 w/EPA #870000915**		**$31.34**
Ventilator therapy initial home visit, patient intake and evaluation. **Allowed one time per provider, per client.**	**94656 w/EPA #870000915**	**94760 w/EPA #870000916**		**52.08**
Pneumocardiogram or polysomnogram **(one year of age and under)** service; with recording equipment. **Not to be used on a routine basis. Use only when medically indicated**.	**94772 w/EPA #870000917**			**156.73**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Suction Pump/Supplies

Tracheal suction catheter, closed system, each. **Limit 1 per day per client.**	**A4605**	**A4624**		**$16.40**
Tracheal suction catheter, any type, other than closed system, each. **Purchase only. Limit: 150 each month for clients age 8 and older, 300 each month for clients under age 8. Modifier NU required.**	**A4624**	**A4605**		**2.63**
Oropharyngeal suction catheter, each (Yankauer). **Purchase only. Modifier NU required. Limit: 4 per client, every 30 days.**	**A4628**			**3.65**
Canister, disposable, used with suction pump, each. **Purchase only. Modifier NU required. Limit: 5 per client every 30 days for portable pump. 5 per client, every 30 days for stationary pump.**	**A7000**	**A7001**		**9.54**
Canister, non-disposable, used with suction pump, each. **Purchase only. Modifier NU required. Limit: 1 every 12 months.**	**A7001**	**A7000**		**33.08**
Tubing, used with suction pump, each. **Purchase only. Modifier NU required. Limit: 15 per client, every 30 days.**	**A7002**			**3.83**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase
***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*				
Respiratory suction pump, home model, portable or stationary, electric. **Modifier RR or NU required. If billing for the backup unit, use modifier TW in addition to the other required modifier. Limit: 2 in 5 years, one for use in the home and one for back-up or portability. Deemed purchased after 12 months rental.** MAA allows payment for suction supplies, (e.g., gloves and sterile water) when billed by Durable Medical Equipment (DME) providers and pharmacists. See Important Contacts section.	**E0600**		**45.79**	**457.90**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Tracheostomy Care Supplies

Transtracheal oxygen catheter, each	**A4608**		#	#
Tracheostomy, inner cannula (disposable replacement only). **Purchase only.** **Modifier NU required.** **Limit: 1 per client, each day.**	**A4623**			**6.55**
Tracheostomy care kit for new tracheostomy **(includes: basin or tray, trach dressing, gauze sponges, pipe cleaners, cleaning brush, cotton tipped applicators, twill tape, drape, and sterile gloves.)** **Limit: 1 per client, each day.** **Use this code for first 2 weeks only, then use A4629.** **Purchase only.** **Modifier NU required.**	**A4625**	**A4626, A4629**		**3.50**
Tracheostomy cleaning brush, each. **Discontinued for dates of services on and after7/1/05**	**A4626**	**A4625, A4629**		#
Tracheostomy care kit for established tracheostomy **(includes: basin or tray, trach dressing, gauze sponges, pipe cleaners, cleaning brush, cotton tipped applicators, twill tape, drape, and sterile gloves.)** **Limit: 1 per client, each day.** **Use after the first 2 weeks.** **Purchase only.** **Modifier NU required.**	**A4629**	**A4625, A4626**		**3.50**
Tracheostoma valve, including diaphragm, each	**A7501**		#	#
Replacement diaphragm/faceplate for tracheostoma valve, each	**A7502**		#	#
Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each.	**A7503**		#	#
Filter for use in a tracheostoma heat and moisture exchange system, each.	**A7504**		#	#

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Tracheostomy Care Supplies (cont.)

Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each.	**A7505**		#	#
Adhesive disc for use in a heat and moisture exchange system and/or with tracheostoma valve, any type, each.	**A7506**		#	#
Filter holder and integrated filter without adhesive, for use in a tracheostoma heat and moisture exchange system, each.	**A7507**		#	#
Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each.	**A7508**		#	#
Filter holder and integrated filter housing, and adhesive, for use as tracheostoma heat and moisture exchange system, each. (Condenser, disposable e.g., artificial nose.) **Limit: 1 each day for clients age 8 and older.** **Limit: 3 each day for clients under age 8. Purchase only.** **Modifier NU required.**	**A7509**			**1.41**
Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each. **Limit per client, per month: 1 if removable inner cannula or 4 each month if no removable inner cannula.**	**A7520**			**47.48**
Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each. **Limit: 1 per client every 30 days if removable inner cannula or 4 per client every 30 days if no removable inner cannula.**	**A7521**			**$47.05**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Tracheostomy Care Supplies (cont.)

Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each. **Limit: 1 per client every 30 daysif removable inner cannula or 4 per client every 30 days if no removable inner cannula.**	**A7522**			**45.16**
Tracheostomy shower protector, each	**A7523**		**#**	**#**
Tracheostoma stent/stud/button, each	**A7524**		**#**	**#**
Tracheostomy mask, each **Purchase only.** **Modifier NU required.** **Limit: 4 per client, every 30 days.**	**A7525**			**2.07**
Tracheostomy tube collar/holder, each. **Limit: 15 per client, every 30 days.**	**A7526**			**3.37**
Tracheostomy/laryngectomy tube plug/stop.	**A7527**		**#**	**#**
Tracheostomy speaking valve **Purchase only.** **Modifier NU required.** **Limit: 1 every 6 months.**	**L8501**			**96.88**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Ventilators and Related Respiratory Equipment

Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube). (Payment includes all necessary accessories, fittings and tubing.)* **Rental only.** **Modifier RR required.**	**E0450**	**A4611-A4613, A4616-A4618, E0460, E0461, E0550, E0471, E0472**	**811.34**	
Pressure support ventilator with volume control mode, may include pressure control mode, used with **invasive** interface, e.g. trach tube).	**E0463**	**E0464**	**#**	**#**
Pressure support ventilator with volume control mode, may include pressure control mode, used with **non-invasive** interface, e.g. mask.	**E0464**	**E0464**	**#**	**#**
Respiratory assist device, bi-level pressure capability, with backup rate feature, used with **noninvasive** interface, e.g., nasal or facial mask. (Intermittent assist device with continuous positive airway pressure device). (Payment includes all necessary accessories, fittings and tubing.)* **Rental only.** **Modifier RR required.** **Limit: 1 every 30 days.**	**E0471**	**A4611-A4613, A4616-A4618, E0450, E0460, E0461, E0470, E0472, E0550, E0601**	**$642.17**	
Respiratory assist device, bi-level pressure capability, with backup rate feature, used with **invasive** interface, e.g., tracheostomy tube. (Intermittent assist device with continuous positive airway pressure device). **Rental only.** **Modifier RR required.** **Limit: 1 every 30 days.**	**E0472**	**A4611-A4613, A4616-A4618, E0450, E0460, E0461, E0470, E0471, E0550, E0601**	**642.17**	

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	71/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Ventilators and Related Respiratory Equipment (cont.)

Negative pressure ventilator; portable or stationary. (Payment includes all necessary accessories, fittings, and tubing.)* **Rental only.** **Modifier RR required.** **Limit: 1 every 30 days.**	**E0460**	**A4611-A4613, A4616-A4618, E0450, E0461, E0550, E0471, E0472**	**733.57**	
Volume ventilator, stationary or portable, with backup rate feature, used with non-invasive interface. **Rental only.** **Modifier RR required.** **Limit: 1 every 30 days.**	**E0461**	**A4611-A4613, A4616-A4618, E0450, E0460, E0550, E0471, E0472**	**1,002.05**	
Humidifier heater, with temperature monitor and alarm. (Limited to clients that are mechanically ventilated or clients that have tracheostomies and require heated humidification). **Rental only. Modifier RR required.**	**E1399 w/EPA #870000903**	**E0550**	**128.80**	

***For owned ventilators and CPAPs** – Use modifier "MS" when claiming a six-month maintenance check. Limit of one per six months allowed. Maintenance checks are paid at 50% of the rental rate. **Modifier "U2" required when claiming a secondary "backup" ventilator for the same client.**

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Miscellaneous

Tape, non-water-proof, per 18 square inches.	**A4450**			**$.09**
Tape, waterproof, per 18 square inches.	**A4452**			**.36**
Peak expiratory flow rate meter, hand held. **Purchase only.** **Modifier NU required.** **Limit: 3 per client, every 12 months.**	**A4614**			**23.78**
Oximeter device for measuring blood oxygen levels non-invasively. (Complete with all necessary accessories and supplies except probes.) **Rental only; price per month.** **Modifier RR required**. **Prior authorization required for clients 18 and older.**	**E0445**		**60.00**	
Oximeter probe\sensor, disposable. Purchase only. **Modifier NU required.** **Limit: 4 per client, every 30 days.**	**E1399 w/EPA #870000907**	**A4606**		**26.00**
Oxygen probe for use with oximeter device, replacement. **Non-disposable. Purchase only.** **Modifier NU required.** **Limit: 1 per client, every 30 days.**	**A4606**	**E1399 w/EPA #870000907**		**179.46**
Resuscitator bag; non-disposable, adult/pediatric size. **Purchase only.** **Modifier NU required.** **Limit: 2 per client, per lifetime.**	**E1399 w/EPA #870000910**	**E1399 w/EPA #870000909**		**$134.11**
Resuscitator bag; disposable, adult/pediatric size. **Purchase only.** **Modifier NU required.** **Limit: 2 per client, per lifetime.**	**E1399 w/EPA #870000909**	**E1399 w/EPA #870000910**		**50.99**
~~Non-routine replacement parts for equipment repair. For puchased equipment only. Must bill with statement of warranty coverage. See repair policy for documentation requirements.~~	~~**E1399 w/EPA #870000908**~~			~~**BR**~~

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase

***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*

Miscellaneous (cont.)

Repair or nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. **For purchased equipment only. Must bill actual repair cost and statement of warranty coverage, see repair policy. Requires Prior Authorization.**	**E1340**			**17.43**
Durable medical equipment, miscellaneous **Also includes non routine replacement parts for repair of client owned equipment. Refer to pages E.6 and E.7 of Billing Instructions. Prior authorization required.**	**E1399**			**BR**
Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler (e.g., Aerovent). **Limit: 6 per child (17 and younger), every 12 months; 3 per adult, (18 and older) every 12 months.**	**A4627**			**23.70**
Flutter device. **Purchase only. Modifier NU required. Limit: 1 every 6 months.**	**S8185**			**42.40**
Swivel adaptor	**S8186**		#	#
Tracheostomy supply, not otherwise classified	**S8189**		#	#
Electronic spirometer (for microspirometer)	**S8190**		#	#
Mucus trap	**S8210**		#	#
Percussor, electric or pneumatic, home model. **Purchase only. Modifier NU required. Limit: 1 per client, per lifetime.**	**E0480**			**439.40**
Intrapulmonary percussive ventilations system and related accessories.	**E0481**		#	#
Cough stimulating device, alternating positive and negative airway pressure. Prior authorization required. Rental only, per month. **Modifier RR required. Limit: 1 per client, per lifetime. Deemed purchased after twelve months of rental.**	**E0482**		**430.02**	

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Description	HCPCS Code	Do Not Bill With	7/1/05 Rental	7/1/05 Purchase
***HCPCS codes with a "#" symbol in the Rental or Purchase columns are not covered by MAA.*				
High frequency chest wall oscillation air-pulse generator system, (includes hoses and vest), each. Rental includes vest and generator, all repairs and replacements. Manufacturer will replace vest (during either rental or purchase period) for change in user's size. **Modifier RR required.** **Prior authorization required.** **Limit: 1 per client, per lifetime. Deemed purchased after twelve months of rental.**	**E0483**		**1,063.13**	
Oscillatory positive expiratory pressure device, non-electric, any type, each.	**E0484**		#	#

Some policies are noted in this fee schedule for your convenience. Please refer to the narrative sections in the billing instructions for complete policy details.

Miscellaneous Equipment Reimbursed Only When Client Owns Core Equipment

Battery, heavy duty; replacement **for patient-owned ventilator.** (gel cell only) **Purchase only.** **Modifier NU required.** **Limit: 1 every 2 years.**	**A4611**	**E0450, E0460, E0471**		**166.98**
Battery cables; replacement **for patient - owned ventilator**. **Purchase only.** **Modifier NU required.** **Limit of 1 every 2 years.**	**A4612**	**E0450, E0460, E0471**		**76.77**
Battery charger; replacement **for patient - owned ventilator**. (gel cell only) **Purchase only.** **Modifier NU required.** **Limit of 1 every 2 years.**	**A4613**	**E0450, E0460, E0471**		**144.21**
Cannula, nasal. **For client -owned equipment.** **Purchase only.** **Modifier NU required.** **Limit: 2 per client, every 30 days.**	**A4615**	**E0424, E0431, E0434, E0439**		**1.84**
Tubing (oxygen), per foot. **For client - owned equipment.** **Purchase only.** **Modifier NU required.**	**A4616**	**E0424, E0431, E0434, E0439, E1390, E0450, E0460, E0471**		**.09**
Mouthpiece. **For client -owned equipment. Purchase only.** **Modifier NU required.** **Limit: 4 per client, every 30 days.**	**A4617**	**E0424, E0431, E0434, E0439, E0450, E0460, E1390, E0471**		**1.91**

Miscellaneous Equipment Reimbursed Only When Client Owns Core Equipment (cont.)

Breathing circuits. **For use with client - owned equipment.** **Purchase only.** **Modifier NU required.** **Limit: 4 per client, every 30 days.**	**A4618**	**E0424, E0431, E0434, E0439, E0450, E0460, E1390, E0471**		**7.66**
Variable concentration mask. **For client-owned equipment.** **Purchase only.** **Modifier NU required.** **Limit: 4 per client, every 30 days.**	**A4620**	**E0424, E0431, E0434, E0439, E1390**		**2.58**
Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery. **Rental only.** **Modifier RR required. (Not billable when used with rented ventilator or rented oxygen equipment.)** **Only allowed for IPPB** **Limit: 1 every 30 days.**	**E0550**	**A4615, E0424, E0431, E0434, E0439, E0441, E0450, E0460, E0471, E1390, E1399 w/EPA #870000903**	**42.61**	
Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flow meter.	**E0555**		**#**	**#**
Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery.	**E0560**		**#**	**#**

Expedited Prior Authorization (EPA) Criteria:

Refer to Prior Authorization Section of Billing Instructions for instructions and documentation requirements for EPA.

Oxygen Equipment and Supplies

Criteria	Last 3 digits	Billing Code	Do Not Bill With	Rental	Purchase
Use E0570 when billing for a Nebulizer when ALL of the following are true: **1) Diagnosis of acute bronchiolitis 466.11,** OR 466.19**, or acute bronchiolitis 466.0.** **2) Client has a definitive respiratory diagnosis requiring the administration of nebulized medications (MAA will not accept a diagnosis such as abnormal secretions); and** **3) Diagnosis justifying the use of a nebulizer is on the claim.** **Purchase price is amount allowed after 2 months mandatory rental.** **Modifier NU or RR required.**	**900**	**E0570**	E0500	$16.10	$128.80
Use E1399 when billing for "Fish" **(3cc-5cc saline vials), each.** Limit: 200 per client every 30 days.	901	E1399			.23

Criteria	Last 3 digits	Billing Code	Do Not Bill With	Rental	Purchase
Use E1399 when billing for Humidifier heater, with temperature monitor and alarm **when all of the following are true:** **1) Heated humidification is medically necessary;** and **2) The client is either mechanically ventilated or has a tracheostomy.** Per Month Rental only. Modifier RR required.	903	E1399	E0550	128.80	
Use E1399 when billing for Apnea Belt Kit **(includes 2 belts, 4 electrodes, and 4 lead wires), each.** Purchase only. Modifier NU required. Limit: 2 per client, every 30 days.	904	E1399	A4556, A4557		25.92
Use E1399 when billing for Oximeter probe\sensor, disposable, each. **Purchase only. Modifier NU required.** Limit: 4 per client, every 30 days.	907	E1399			26.00
~~**Use E1399 when billing for** Non-routine replacement parts **for equipment repairs when all of the following are true:** **1) Equipment is owned by the client;** **2) Warranty for both equipment and parts has expired; and** **3) There is no evidence of malicious damage, culpable neglect or wrongful~~	~~908~~	~~E1399~~			~~BR~~

Criteria	Last 3 digits	Billing Code	Do Not Bill With	Rental	Purchase
~~**disposition of equipment.**~~ ~~**Documentation of above information is in the client's record.**~~ **For dates of service on or after 07/01/05, use E1399 (durable medical equipment, misc.) which requires prior authorization.**					
Resuscitator bag, disposable, adult/pediatric size. **Purchase only.** **Modifier NU required.** **Limit: 2 per client, per lifetime**	909	E1399			50.99
Resuscitator bag, non-disposable, adult/pediatric size. **Purchase only.** **Modifier NU required.** **Limit: 2 per client, per lifetime**	910	E1399			134.11
Sterile water or sterile saline. 1000 ml, used with large volume nebulizer. Limit: 50 per client, every 30 days.	928	E1399			2.74

Professional Services Performed by Washington State Licensed Professionals Operating Within the Scope of Their Practice

Reimbursement includes cost of taking equipment into a client's home.

Criteria	Last 3 digits	Billing Code	Do Not Bill With	Purchase
Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day – (when the visit includes, at a minimum all of the following)*:* 1) Evaluation of Access; 2) Identification Emergency exits; 3) Verification of proper electrical grounding; 4) Identification of functioning communication devices; 5) Identification of adequate lighting; 6) Preparation or evaluation of emergency plans; 7) Notification of emergency services and electricity providers; and 8) Documentation of above activities and findings. **Must be performed by professional staff.** **Limit: 1 per client per lifetime.**	**915**	**94656**		**52.08**
Noninvasive ear or pulse oximetry for oxygen saturation; single determination. **Limit: 1 per 6 months**	**916**	**94760**		**31.03**
Circadian respiratory pattern recording (pediatric pneumogram), 12 to 24 hour continuous recording, infant. (Not to be used on a routine basis. Use only when medically necessary.)	**917**	**94772**		**155.18**

How do I bill for clients who are eligible for both Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their medical ID card in addition to QMB)

- If Medicare **and** Medicaid cover the services, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **and not Medicare** covers the service and the service is covered under the CN or MN program, MAA will reimburse for the service.

QMB-Medicare Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare's or Medicaid's allowed amount, whichever is less.
- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.
- If **Medicare does not** cover the service, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's DSHS Medical ID Card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet MAA's and the insurance carrier's requirements relating to billing time limits, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding MAA's programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
(Refer to WAC 388-502-0020[2])

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's Medical ID card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

NOTE: Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a **B** in *field 19* to indicate the baby is on a parent's PIC.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.* **If you have more than one EPA number to bill, place both numbers here.**

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
12	Client's residence
31	Skilled Nursing facility
32	Nursing facility
99	Other

24C. **Type of Service**: Not Required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed. **MODIFIER**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not put Medicare payment here or use dollar signs or decimals in this field.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: Please enter your seven-digit provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JD020155SMITHB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH JANE

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 55 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 BRIDGEPORT WAY

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR MARY DOE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1010101

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 492.8 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 01 03	10 31 03	12		E0439	RR	492.8	19564	1				
2 10 01 03	10 31 03	12		E0434	RR	492.8	3619	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 23183

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 23183

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RESPIRATORY THERAPY
100 MAIN ST
ANYTOWN WA 98000 206-555-1111

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

How to Complete the Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID card. This information consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: C010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403).

24B. **Place of Service**: Required. Enter the appropriate number below:

Code Number	To Be Used For
12	Client's residence
31	Skilled Nursing facility
32	Nursing facility

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. **Coinsurance and Deductible**: Enter the total combined and deductible for each service in the pace to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., January 4, 2000 = 010400).

24B. **Place of Service**: Required. Enter the appropriate number below:

Code Number	To Be Used For
12	Client's residence
13	Assisted living facility
31	Skilled Nursing facility
32	Nursing facility
99	Other place of service

24C. **Type of Service**: No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. **Coinsurance and Deductible**: Enter the total combined and deductible for each service in the pace to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

MEDICARE PARTB/MEDICAID CROSSOVER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JD020155SMITHB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH JANE

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 55 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 BRIDGEPORT WAY

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR MARY DOE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1010101

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 492.8 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	31	03	12		E0431	RR	492.8	3619	30				20.06
2	10	01	03	10	01	03	12		E0441		492.8	15520	1				122.10
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. $ TOTAL CHARGE: 19139

29. $ AMOUNT PAID: 8830

30. $ BALANCE DUE: 10309

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/12/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RESPIRATORY THERAPY
100 MAIN ST
ANYTOWN WA 98000 206-555-1111

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

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